g) Excision: bartholin cyst, condylomas, foreign body, lesions lipoma, nevi (moles), sebaceous cyst, polyps, and subcutaneous fistulas.
h) Extraction: foreign body, and teeth (per existing policy).
i) Graft, skin (pinch, splint of full thickness up to defect size 3/4 inch diameter).
j) Hymenotomy.
k) Manipulation and/or reduction with or without x-ray; cast change: dislocations depending upon the joint and indication for procedure, and fractures.
l) Meatotomy/urethral dilation, removal calculus and drainage of bladder without incision.
m) Myringotomy with or without tubes, otoplasty.
n) Oscopy with or without biopsy (with or without salpingogram): arthroscopy, bronchoscopy, colonoscopy, culdoscopy, cystoscopy, esophagoscopy, endoscopy, otoscopy, and sigmoidoscopy or proctosidmoidoscopy.
o) Removal: IUD, and fingernail or toenails.
p) Tenotomy hand or foot.
q) Vasectomy.
r) Z-plasty for relaxation of scar/contracture.

d. Abortion services are reimbursable under the Medical Assistance Program only when service to provide an abortion or induce miscarriage is, in the opinion of a physician, necessary for the preservation of the life of the woman seeking such treatment or to comply with the federal court order in the case of Hope vs. Childers. Any request for program payment for an abortion or induced miscarriage must be justified by a signed physician certification documenting that in the physician's opinion the appropriate circumstances, as outlined in sentence one of this paragraph, existed. A copy of the completed certification form and an operative report shall accompany each claim submitted for payment. However, when medical services not routinely related to the uncovered abortion service are required, the utilization of an uncovered abortion service shall not preclude the recipient from receipt of medical services normally available through the Medical Assistance Program.

2a. Outpatient Hospital Services

Hospital outpatient services are limited to therapeutic and diagnostic services as ordered by a physician or if applicable, a dentist; to emergency room services in emergency situations; and to drugs, biologicals, or injections administered in the outpatient hospital setting (excluding "take home" drugs and those drugs deemed less-than-effective by the Food and Drug Administration).

Abortion services are reimbursable under the Medical Assistance Program only when service to provide an abortion or induce miscarriage is, in the opinion of a physician, necessary for the preservation of the life of the woman seeking such treatment or to comply with the federal court order in the case of Hope vs. Childers. Any request for program payment for an abortion or induced miscarriage must be justified by a signed physician certification

documenting that in the physician's opinion the appropriate circumstances, as outlined in sentence one of this paragraph, existed. A copy of the completed certification form and an operative report shall accompany each claim submitted for payment. However, when medical services not routinely related to the uncovered abortion service are required, the utilization of an uncovered abortion service shall not preclude the recipient from receipt of medical services normally available through the Medical Assistance Program.

2b. Rural Health Clinic Services

Other ambulatory services furnished by a rural health clinic shall have the same limitations when provided by the rural health clinic as when provided by the usual ambulatory care provider as specified in the relevant subsections of Attachment 3.1-A pertaining to those ambulatory services, except that limitations pertaining to qualifications of provider shall not apply. Reimbursement is not made for the service of physician assistants.

With regard to services provided on or after October 1, 1988, rural health clinics will be allowed to secure drugs for specified immunizations from the Department for Public Health free to provide immunizations for Medicaid recipients. The specified immunizations are: diphtheria and tetanus toxoids and pertussis vaccine (DPT); measles, mumps, and rubella virus vaccine, live (MMR); poliovirus vaccine, live, oral (any types(s)) (OPV); and hemophilus B conjugate vaccine (HBCV).

2c. Federal Qualified Health Center Services

Federal qualified health center (FQHC) services are limited to FQHC services as defined in the Social Security Act, including ambulatory services offered by a FQHC and which are included in the state plan.

3. Other Lab and X-Ray Services

Laboratory Services limited to a benefit schedule of covered laboratory procedures when ordered or prescribed by a duly-licensed physician or dentist.

4.a. Nursing Facility Services (Other Than Services in an Institution for Mental Diseases) for Individuals 21 Years of Age or Older

A. Definitions:

1. "High intensity nursing care services" means care provided to Medicaid eligible individuals who meet high intensity patient status criteria which shall be equivalent to skilled nursing care standards under Medicare.

2. "Low intensity nursing care services" means care provided to Medicaid eligible individuals who meet low intensity patient status criteria which shall be equivalent to the former intermediate care patient status standards.

3. "Intermediate care for the mentally retarded and persons with related conditions services" means care provided to Medicaid eligible individuals who meet ICF-MR patient status criteria by ICF-MRs participating in the Medicaid Program.

B. Services:

Program benefits are limited to eligible recipients who require nursing facility care services meeting the above definitions. These services must be preauthorized and must be reevaluated every six (6) months. If the reevaluation of care needs reveals that the patient no longer requires high intensity, low intensity, or intermediate care for the mentally retarded services and payment is no longer appropriate in the facility, payment shall continue for ten (10) days to permit orderly discharge or transfer to an appropriate level of care.

All individuals receiving nursing facility care must be provided care in appropriately certified beds.

The following services are payable by the Medicaid Program when they are medically necessary and ordered by the attending physician. The facilities may not charge the Medicaid recipient for these services. (Also see Attachment 4.19-D Exhibit B for a detailed explanation of each service or item.)

(1) Routine services include a regular room (if the attending physician orders a private room, the facility cannot charge the family or responsible party any difference in private/semi-private room charges; the facility enters their charges for a private room when billing Medicaid), dietary services and supplements, medical social services, nursing services, the use of equipment and facilities, medical and surgical supplies, podiatry services, items which are furnished routinely and relatively uniformly to all patients, prosthetic devices, and laundry services (including laundry services for personal clothing which is the normal wearing apparel in the facility).

(2) Ancillary services are those for which a separate charge is customarily made. They include physical therapy, occupational therapy, speech therapy, laboratory procedures, X-ray, oxygen and oxygen supplies, respiratory therapy, and ventilator therapy.

4.b. Early and Periodic Screening and Diagnosis of Individuals Under 21 Years of Age and Treatment of Conditions Found.

A. Dental Services

(1) Out-of-Hospital Care

A listing of dental services available to recipients under age 21 is maintained at the central office of the single state agency and shown in provider manual.

Services not listed in the provider manual will be pre-authorized when medically necessary.

(2) In-Hospital Care

(a) Coverage for services rendered by dentists for hospital inpatient care is limited to services for patients that are determined to be medically necessary. This includes, but is not limited to, patients with:

1) Heart disease
2) Respiratory disease
3) Chronic bleeder
4) Uncontrollable patient (retardate-emotionally disturbed)
5) Other (car accident, high temperature, massive infection, etc.)

B. Hearing Services

Audiological Benefits

(a) Coverage is limited to the following services provided by certified audiologists:

1) Complete hearing evaluation;
2) Hearing aid evaluation;
3) A maximum of three follow-up visits within the six-month period immediately following fitting of a hearing aid, such visits to be related to the proper fit and adjustment of that hearing aid;
4) One follow-up visit six months following fitting of a hearing aid, to assure patient's successful use of the aid.

Services not listed above will be provided when medically necessary upon appropriate pre-authorization.

(b) Exception to the above limitations may be made through preauthorization if need is indicated in the individual case.

(2) Hearing Aid Benefits

Coverage is provided on a pre-authorized basis for any hearing aid model recommended by a certified audiologist so long as that model is available through a participating hearing aid dealer.

C. Vision Care Services (EPSDT Children Under 21 Years of Age)

(1) Optometrists' services are provided to children under 21 years of age who are EPSDT eligible recipients. Coverage includes writing of prescriptions, services to frames and lenses, and diagnostic services provided by ophthalmologists and optometrists, to the extent the optometrist is licensed to perform the services and to the extent the services are covered in the ophthalmologist portion of the physician's program. Eyeglasses are provided only to children under age 21 on a pre-authorized basis. Coverage for eyeglasses is limited to two (2) pairs of eyeglasses per year per person. This limitation includes the initial eyeglasses and one (1) replacement per year or two (2) replacements per year. All services, other than examinations or diagnosis procedures, must be prior authorized.

(2) Beyond the limits specified above or for services not covered under the Title XIX state plan, Kentucky will determine the medical necessity for the EPSDT services on a case by case basis through prior authorization.

1. Inpatient Hospital Services

a. Payment is made for inpatient hospital care as medically necessary. Each admission must have prior approval of appropriateness by the designated peer review organization in order for the admission to be covered under the Medicaid program; this requirement does not apply to emergency admissions. Weekend stays associated with a Friday or Saturday admission will not be reimbursed unless an emergency exists. Covered admissions are limited to those admissions primarily indicated in the management of acute or chronic illness, injury, or impairment, or for maternity care that could not be rendered on an outpatient basis. Admissions relating to only observation or only diagnostic purposes or for elective cosmetic surgery shall not be covered. Laboratory tests not specifically ordered by a Physician and not done on a preadmission basis where feasible will not be covered unless an emergency exists which precludes such preadmission testing

b. A recipient may transfer from one hospital to another hospital when such transfer is necessary for the patient to receive medical care which is not available in the first hospital. In such situations, the admission resulting from the transfer is an allowable admission.

c. The following listed surgical procedures are not covered on an inpatient basis, except when a life threatening situation exists, there is another primary purpose for the admission, or the admitting physician certifies a medical necessity requiring admission to a hospital:

(a) Biopsy: breast, cervical node, cervix, lesions (skin subcutaneous, submucous), lymph node (except high axillary excision, etc.), and muscle.
(b) Cauterization or cryotherapy: lesions (skin, subcutaneous, submucous), moles, polyps, warts/condylomas, anterior nose bleeds, and cervix.
(c) Circumcision.
(d) Dilation: dilatation and curettage (diagnostic or therapeutic non-obstetrical); dilatation/probing of lacrimal duct.
(e) Drainage by incision or aspiration: cutaneous, subcutaneous, and joint
(f) Exam under anesthesia (pelvic).

4.b EPSDT Services (continued)

D. Discretionary Services under EPSDT. For neonatal care related to any of the following diagnoses, an infant (i.e., child not more than twelve (12) months of age) EPSDT eligible recipient may transfer from a hospital with a level III neonatal unit to a different hospital with a level II or level I neonatal unit with the transfer considered a new admission. A "level III neonatal unit" means a unit able to provide the full range of resources and expertise required for the management of any complication of the newborn; a nurse/patient ratio of 1:2 is required. A "level II neonatal unit" means a unit able to provide care to the moderately ill infant who requires various support services; a nurse/patient ratio of 1:4 is required. A "level I neonatal unit" means a unit providing care to infants with uncomplicated conditions; normal nursery staffing is required.

Neonatal Related Diagnoses

(1) Fetus or newborn affected by maternal conditions, which may be unrelated to present pregnancy.
(2) Fetus or newborn affected by maternal complications of pregnancy.
(3) Fetus or newborn affected by complications of placenta, cord, and membranes.
(4) Fetus or newborn affected by other complications of labor and delivery.
(5) Slow fetal growth and fetal malnutrition.
(6) Disorders relating to short gestation and unspecified low birthweight.
(7) Disorders relating to long gestation and high birthweight.
(8) Birth Trauma
(9) Intrauterine hypoxia and birth asphyxia.
(10) Respiratory distress syndrome.
(11) Other respiratory conditions of fetus and newborn.
(12) Infections specific to the perinatal period.
(13) Fetal and neonatal hemorrhage.
(14) Hemolytic disease of fetus or newborn, due to isoimmunization.
(15) Other perinatal jaundice.
(16) Endocrine and metabolic disturbances specific to the fetus and newborn.
(17) Hematological disorders of fetus and newborn.
(18) Perinatal disorders of digestive system.
(19) Conditions involving the integument and temperature regulation of fetus and newborn
(20) Congenital anomalies and related surgical procedures.
(21) Other and ill-defined conditions originating in the perinatal period.

4.b. EPSDT Services (continued)

E. The Medicaid program shall provide such other necessary health care, diagnostic services, treatment, and other measures described in Section 1905(a) of the Social Security Act to correct or ameliorate defects and physical and mental illness and conditions discovered by the screening services, whether or not such services are covered under the state plan.